Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL
4243 EAST SOUTHCROSS
SAN ANTONIO TX 78222

Respondent Name

LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-0361-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital for preauthorized services no choice but to seek medical fee dispute resolution. Further, the insurance carrier failed to properly pay for implants plus the necessitated hospital stay and supplies from the surgery."

Amount in Dispute: $57,644.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization #092650468L001001 was requested and given for the surgical procedures requested and a one (1) day inpatient admission day. The claimant was admitted for a three (3) day inpatient stay as evidenced by the UB04 and records submitted. Liberty Mutual's Utilization Review Department has no record of a request for preauthorization for extension of these additional two (2) days of inpatient stay as required by Texas Administrative Code Rule (14) (q)(1) concurrent review. As such these additional days were denied as pre-authorization was required, but not requested for this service per DWC Rule 134.600." "According to TDI Rule 134.404 the definition of implantable is an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and related equipment necessary to operate, program and recharge the implantable. With regards to the items billed as implantables of Cell Packer and Vitagel Surgical Hemostatic, these items are not considered implantables and charges were denied as included in the facility fees as not separately payable as implants." "This hospital bill was processed to pay @ 143% of the Medicare rate for DRG 490…" There was no outlier payment applicable." "Liberty Mutual believes that Innova Hospital San Antonio has been appropriately reimbursed…."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2009 Through September 30, 2009	Inpatient Hospital Surgical Services	$57,644.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
4. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
5. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
6. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.'"
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 16, 2009
   - 62- X170 – PREAUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.
   - 97- X094 – CHARGES INCLUDED IN THE FACILITY FEE.
   - 150 – Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

   Explanation of benefits dated February 9, 2010
   - 62- X170 – PREAUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.
   - 97- X094 – CHARGES INCLUDED IN THE FACILITY FEE
   - 150 – Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the requestor obtain preauthorization approval for the length of stay prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Did the respondent raise new denial reasons or defenses?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. The respondent's response to the DWC060 asserts that Preauthorization #092650468L001001 was given for one (1) day inpatient admission day. Review of the requestor's preauthorization request for, indicates length of stay, 1 day. The claimant was admitted for a three (3) day inpatient stay as noted on the UB04 and records submitted. 28 Texas Administrative Code, Section §134.600(p)(1) requires preauthorization of "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." 28 Texas Administrative Code, Section §134.600(q)(1) states, "The health care requiring concurrent review for an extension for previously approved services includes: inpatient length of stay." Review of the submitted documentation finds no documentation to support an extension of length of stay. The division finds that the respondent denial reason is supported. No additional reimbursement is due for the length of stay.
3. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).
4. 28 Texas Administrative Code §133.307(d)(2)(B) states in pertinent part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses shall not be considered in the review." The respondent raised new defenses in their position summary and shall not be considered.
5. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 490 is $8,070.65.

   This amount multiplied by 108% is $8,716.30.

   The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $1,040.00.

   The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $104.00.

   The total maximum allowable reimbursement (MAR) is $9,860.30.

   The Division concludes that the requestor is entitled to $0.00 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2011 Date
Signature	Medical Fee Dispute Resolution Manager	***October 19 , 2011*** Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.